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ABSTRACT

A representative sample of California school psychologists was surveyed to determine the extent of the use of the Adaptive Behavior Scale and the relationship between training in the use of the scale and perceptions of the efficacy of its measures. A large majority of psychologists had used the scale two or fewer times, though 30-45% had been introduced to the scale in assessment workshops, trained others, or participated in special courses. In general, the more extensive the training, the more positive the judgment of the psychologists about the utility of the adaptive behavior assessment the scale provides. The outcomes of evaluations which used the Adaptive Behavior Scale, from a school district in which psychologists reported being trained, were analyzed. It was concluded that the information from the Adaptive Behavior Scale contributed important diagnostic information to the evalution and placement process. It was also noted that the Spanish-surnamed children always had the lowest scores on the Physical Development domain, indicating the possibility of sensory and motor handicaps. (Author/BW)

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Field Study of the Efficacy of the AAMD Adaptive Behavior Scale - Public School Version

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Issues in the Application of the Public School Version of the AAMD Adaptive Behavior Scale in School Setting

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Substudy 5 of 5

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Foreward

The study reported here was part of a program of research in Special Education by Nadine M. Lambert.

The study was carried out during the academic year 1976-1977 under the auspices of the Special Education Research Program, supported by Grant No. 76-62-G between the State Department of Education and Nadine M. Lambert.

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Issues in the Application of the Public School Version of the AAMD Adaptive Behavior Scale in School Setting

Abstract

In substudy 5 we inquired into the extent of use of the Adaptive Behavior Scale and the relationship between training in the use of the Scale and perceptions of the efficacy of its measures. A second objective was to examine the adaptive behavior profiles of children with different placement outcomes.

Our findings from a survey of representative school psychologists showed that 80% had obtained teacher ratings of adaptive behavior on the Scale 10 or fewer times, and 30% of this group reported never having used the Scale at all. We concluded that a large majority of psychologists could not be considered proficient in the use of the Scale if one considered the number of Scales administered as a criterion of competence.

We next examined the relationship of training in the use of the Scale and perceptions of the Scale's usefulness. On the basis of the training criteria which we defined, we concluded that about 30 to 45% of psychologists had been introduced to the Scale in assessment workshops, trained others or participated in special courses, all of which would be necessary before one could be assumed to have a minimal level of assessment competence. The importance of training was shown to be crucial in the psychologist's evaluation of the adequacy of the obtained measures and the usefulness of the Scale for placement and program decisions. In general, the more extensive the training, the more positive the judgment of the psychologist about the utility of the adaptive behavior assessment the Scale provides.

We analyzed the outcomes of evaluations which used the Adaptive Behavior Scale from a school district in which psychologists reported being trained. The detailed examination of the profiles of children in regular and EMR classes with differing outcomes showed that those children in regular classes

after the assessment had higher adaptive behavior scale profiles than those who were considered eligible for EMR placement. Even though we had no data on other types of information which contributed to the outcomes, we concluded that the information from the Adaptive Behavior Scale contributed important diagnostic information to the evaluation and placement process.

The similarities of adaptive behavior profiles among children of different ethnic groups with various placement outcomes were also reviewed. While there were few differences among ethnic groups within the same outcome group, it is worthy of note that the Spanish-surnamed children always had the lowest scores on the Physical Develpoment domain indicating the possibility of sensory and motor handicaps and the probability that multiple factors influence the functioning of these children.

Taken together the findings from this substudy of the use of the Scale in public school settings has shown that psychologists are beginning to employ the Adaptive Behavior Scale in their evaluations of children and that training in the use of the Scale is imperative for proper application of the results. The outcomes of pupil evaluations where Adaptive Behavior Scale profiles were available showed that information from adaptive behavior assessment contributed appropriately to educational decisions.

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Background

In October 1974 the California State Board of Education adopted the California Revision of the 1974 Adaptive Behavior Scale pursuant to Section 6902.085 of the Education Code. In its revision, the Board instructed the Superintendent of Public Instruction to report to the Board by January 1, 1978 on the use and results of the adoption of the Adaptive Behavior Scale.

This section of the project examined several aspects of the use of the Adaptive Behavior Scale. Since adaptive behavior is a relatively new concept and the methods for its assessment are unfamiliar to psychologists, we were interested in determining whether psychologists were using the Scale, whether they viewed the Scale as providing accurate assessment of adaptive behavior and whether psychologists' use and perceptions of the value of the Scale were a function of training in adaptive behavior measurement. To understand better the impact of the Education Code mandate to include a measure of adaptive behavior in the assessment of children for programs for the educable mentally retarded, we also explored the outcomes of the use of the scale in determining eligibility for and reevaluations of pupils in special education programs. It was our hope that these findings on the use of the Scale would not only inform educators of the impact of legislative action to broaden the assessment base for the diagnosis of mental retardation, but to raise questions about the extent to which psychologists and others involved in the education of exceptional children were prepared to tackle this most important assessment activity.

Objectives

The objectives of the substudy were:

1. To determine the extent of use of the Adaptive Behavior Scale by a sample of representative school psychologists in California.

2. To provide information on the extent to which psychologists judged the Scale to be of value in the assessment of mentally retarded children and whether their judgments were a function of the number of scales used or a function of training in adaptive behavior assessment.

3. For a sample of school districts which had made extensive use of the Scale to determine:

   a. the age and ethnic status characteristics of children who were being evaluated for special education placement or for reassignment to regular class programs

   b. the placement outcomes of these evaluations and

   c. the differences in adaptive behavior profiles for those accepted for and for those rejected for special or regular class placements.

Methods

Two sources of data were employed in the field study section of the project. Objectives 1 and 2 required a representative sample of psychologists to report on the extent of use of the Scale and their training for administration. The subjects, methods and results of this portion of the field study will be referred to as "training and use of the Adaptive Behavior Scale." To achieve objective 3 necessitated the administration of a large number of Scales to children in special programs who were receiving an annual evaluation, or who were being considered for placement in special

education programs. The subjects, methods and results of this section of the report will be referred to as "outcomes of adaptive behavior assessment."

Subjects

Subjects for evaluating training and use of adaptive behavior assessment. During the 1976-1977 academic year school psychologists in California were invited to participate in a workshop on Comprehensive Assessment for the Learning Handicapped Child. These one day workshops presented material on the assessment of cognitive development, language development, learning proficiency and adaptive behavior. The goal was to introduce school psychologists to contemporary theory and research in each of these areas and to demonstrate the utility of information from such assessment for diagnosing functional level and planning educational programs for normal and exceptional pupils. Though not intended as "training" sessions, in that insufficient time was available to explore in detail each assessment area, the workshops were intended as orientation to these new assessment concepts and materials were provided for psychologists to use when they returned to their districts. The session on adaptive behavior included an overview of the development of the Scale, information on ways to train teachers in the use of the Scale, and a summary of the research which had been conducted on the Scale, most of which is summarized in the "Supplement to the Manual" which was reported as substudy 1 of this project. Workshop time limits prevented an effort to reconcile problems in item rating, profile development and interpretation, or educational planning.

The list of psychologists who had signed up to participate in a workshop during the school year was the group from which a sample was selected. Using random numbers, we identified a 30% sample of the sign-up list and

mailed a questionnaire to the subjects about training, use and perceptions of utility of the Scale. Table 1 provides information on the location of the sample, the and type of districts and the occupation of the respondents.

Subjects for studying outcomes of adaptive behavior assessment. While the subjects for the study of the use of the Adaptive Behavior Scale were school districts and district personnel, the subjects for the study of outcomes of adaptive behavior assessment were the pupils who had been rated on the Scale. In order to obtain a sample of sufficient magnitude, we contacted school districts who were involved in intensive evaluation of children in special education programs. Several large school districts provided us with Adaptive Behavior Scales and supplemental information including data on the characteristics of the pupil being evaluated and the purpose and outcomes of the adaptive behavior evaluation. We obtained Scales and supplemental data for 641 elementary and secondary school subjects from ages 7 through 19. Table 1 displays the distribution of subjects by school placement, age, sex and ethnic status.

Procedures

Procedures for evaluating training and use of adaptive behavior assessment. This portion of the study involved the collection of replies to a questionnaire by a representative sample of psychologists and others interested in assessment of learning handicapped children. The questionnaire was prepared by the project director, and revised after review by State Department of Education staff, and school district directors of special education and pupil personnel services. Each sampled person received the questionnaire with a stamped return envelope. The response rate was 40% of those surveyed. The data analysis provided descriptive data on training and

perceptions of the utility of the Scale.

Procedures for studying outcomes of adaptive behavior assessment. After identifying school districts which were willing to share completed Adaptive Behavior Scales and to prepare the supplemental forms, we arranged to reimburse them for costs in preparing the data to send to the research office. We instructed them to code each subject and to send the data only after all identifying information had been deleted. The completed Scale and supplemental forms were checked for accuracy in the research office, and then keypunched and processed into computer master files for data analysis.

To reply to the objectives, we first summarized the types of pupils, the purpose and the outcomes of the adaptive behavior assessment. We then turned to the outcomes of the assessment. For this task, we centered our attention on the numbers of pupils whose class placement changed at the end of the evaluation period. It is important to note that these evaluations were conducted during a period of time when all California school districts were enjoined from using individual intelligence tests in the determination of eligibility of pupils for educable mentally retarded programs. Data from administration of the Adaptive Behavior Scale were only part of the evaluation process. We had no information about other sources of evaluation data which might have contributed to the decision regarding a pupil's placement. We present in this report Adaptive Behavior Scale data in order to provide information about differences in adaptive behavior functioning of these subjects recognizing that decisions about placement were not being made solely on the basis of the adaptive behavior profile.

Results

Use of the Adaptive Behavior Scale in California Schools

Competence in the administration of any psychological evaluation method is dependent upon training and practice. The individual administration of no fewer than 10 tests is often used as a minimum standard of experience in the use of a psychological instrument. As one can see from Table 3, 80% of those surveyed had used the Adaptive Behavior Scale 10 times or less and one third of these respondents reported never using the Scale at all. We concluded that during the Spring of 1977, two and a half years after the adoption of the Scale, a large majority of psychologists could not be considered proficient in the use of adaptive behavior assessment as inferred from their reported use of the Scale.

Even though the standardization of the Scale was based on teacher ratings, the Manual suggests that parents should be interviewed, as well, in order to provide information on both the school and home functioning of the child. Table 4 informs us of the extent to which the psychologists who were sampled reported gathering adaptive behavior ratings from parents. Thirty percent reported that they had interviewed no parents while the remainder had interviewed 1 or more. Only rarely did a psychologist report contacting more than 10 parents for the purpose of adaptive behavior assessment.

From these data on the number of scales used by the respondents, we concluded that psychologists and other educators are beginning to use the Adaptive Behavior Scale, but that we could not infer that they had generally become proficient in either administration or interpretation based on the number of Scales used by the respondents.

Training in the Use of the Adaptive Behavior Scales

Our next question was to analyze the data to determine whether the questionnaire respondents had been trained in the use of the Scale. Three types of training were identified from the responses:

1. attended the State Department of Education workshop on Comprehensive Assessment which introduced the Adaptive Behavior Scale - a minimal level of training.

2. trained teachers in the use of the Scale - would require careful study and extensive familiarization with the Scale in order to train others - a moderate level of training.

3. participated in other types of training such as district in-service courses, or other workshops - a moderate level of training.

Even though all of the respondents had signed up for the State workshops, 21% of them said they had not attended. Forty four percent of those replying to the questionnaire indicated that they had trained 1 or more teachers and about 28% had attended other workshops or participated in school district in-service programs on adaptive behavior assessment. From these data we concluded that between about 30 to 45% of psychologists have been introduced to the Scale, trained others, or participated in coursework, all of which would be necessary before one could be assumed to have a minimal level of proficiency in the use of the Scale.

Perceived Accuracy and Usefulness of the Scale as a Function of Training

Table 7 tabulates the judgments of the respondents as to the accuracy of adaptive behavior assessment reported by teachers and parents of EMR and TMR pupils, whether the Scale was perceived to be useful for referral of EMR and TMR pupils and the value of the Scale for program decisions.

We have tabulated the responses according to whether the respondent was trained or not trained in the use of the Adaptive Behavior Scale.

The most positive perceptions of the utility of the Scale were reported by those who had participated in the most intensive training programs -- namely district in-service courses. The most negative perceptions of the use of the Scale were reported by those who had not participated in a training program of any type. We conclude that the extent of training is related to the reported utility of the Scale for assessment, referral and program planning. The next question is whether perceptions of the usefulness are a function of number of scales used.

Respondents who had not given the Scale, regardless of their training were generally very positive in their perceptions of the accuracy and usefulness of the instrument. But when those who had not been trained used the Scale, their perceptions of the accuracy and usefulness decreased with the number of Scales administered. Those who attended a State workshop, even if they had no additional training, do not show this trend, but rather maintain a fairly positive attitude regardless of the number of Scales administered.

In general, Table 8 informs us that the sampled psychologists judged the Scale to be a more accurate assessment and a more useful instrument for referal for TMR children than EMR children. Those who are using the Scale also judge the assessment as reported by teachers to be slightly more accurate than those reported by parents.

Training also was directly related to perceptions of the usefulness of the Scale for program decisions. Those who received no training had more negative attitudes about the Scale's utility for educational planning than those with training.

These results lead to the conclusion that the more extensive the training in the use of the Public School Version of the Adaptive Behavior Scale, the more the Scale is judged to provide accurate and useful information about children. The results also raise serious questions about whether school districts should permit psychologists and others to use any assessment procedure without adequate preparation in administration of the instrument and interpretation of the results.

Use of the Adaptive Behavior Scale in Pupil Evaluation

Table 9 displays the frequency and percentage of the pupils to whom the Adaptive Behavior Scale was administered. Of the total number of pupils being evaluated, 51% of the evaluations were annual or periodic evaluations, 16% were conducted to determine eligibility for EMR placements, 7% were to determine eligibility for TMR placement and 25% were being reevaluated for reassignment from special education to regular classes.

When we examined the purpose of evaluation by ethnic status, we found that of the children assessed for annual or periodic evaluations, 38% were black, 36% were white, and 26% were Spanish-surnamed. Of those evaluated to determine eligibility for EMR placement, 39% were black, 35% were Spanish, and 26% were white. The distribution of ethnic status was similar for those being considered for EH placement as 35% were white, 35% were black, and 30% were Spanish. Black children (62%) were much more frequently being evaluated for reassignment to a regular class, 28% of these were white and only 10% of this group were from Spanish-speaking backgrounds. With the exception of this last group of pupils, the ethnic status distribution by purpose of evaluation was similar for the three ethnic groups.

Educational Decisions to Which Adaptive Behavior Assessment May Have Contributed

If we turn our attention to the outcomes of the evaluations for stated

purposes we found that 90% of the children who were being evaluated on an annual of periodic basis remained in their placement with little differences in outcome rates according to ethnic status (white, 88%, black, 90%, and Spanish, 93%). Slightly more black (9%) and Spanish children (7%) changed from special education to a regular class than did white children (3%).

When we examined the outcomes of those children who were being evaluated to determine eligibility for EMR placement, approximately 29% remained in regular classes, and 69% moved from regular to special education classes. White children, however, were more likely to remain in their current placement (59%) than black children (20%) and/or Spanish-background children (17%).

Relatively few children in the sample were being evaluated to determine eligibility for EH placement. Of these, 40% remained in their current program, 42% changed from regular to special education classes and 16% were placed on waiting lists. In these instances, Spanish-surnamed children were much more likely to be placed in an EH class or on a waiting list (85%) than white children (54%) and/or black children (40%).

Some children were being reviewed to determine whether they should be reassigned to a regular class. The placement of 86% of these pupils did not change. All of the Spanish children remained in their current placements, whereas approximately 15% of the white and black children were changed to regular classes.

From the data we were able to obtain, it was difficult to determine the extent to which the adaptive behavior profile information was the deciding factor in the placement decisions. Our data do indicate that the Scale is being used in districts in periodic evaluations, for evaluation for reassignment from special education to regular school programs and to determine eligibility for EMR and EH classes.

Adaptive Behavior Profiles of Children with Different Evaluation Outcomes

Some idea of the extent to which the results of adaptive behavior assessments were factors in the determination of eligibility for placement in a special education program can be inferred from the adaptive behavior characteristics of children differing with respect to outcomes. Since training was a key factor in the psychologist's perception of the utility of the Scale, we identified a school district in which a large proportion of psychologists reported that they had participated in the training programs and plotted the profiles of the children according to placement decisions. Specifically, we looked at all cases between the ages of seven and 12 who were evaluated to determine eligibility for EMR placement, with the outcome being either remaining in the current placement, or changing from a regular to a special class placement. The majority of these children were in regular classes before the evaluation although a smaller number were initially classified as EMR. All of the EMR pupils remained in EMR classes following the evaluations. We therefore examined three possible outcomes within the group of children evaluated for the purpose of determining eligibility for EMR placement:

1. Classified as regular, remain in regular class following evaluation (3 subjects).

2. Classified as regular, change to special education class following evaluation (39 subjects).

3. Classified as EMR, remain in EMR class (9 subjects).

The AAMD Adaptive Behavior profiles of these groups of children are reported in the accompanying tables as mean percentile ranks corresponding to the norms for regular class children. After presentation of the data for all subjects in each of the above three groups, we also examined outcomes by ethnic status.

Table 10 displays the mean adaptive behavior domain scores for the three groups of children who were being evaluated for EMR placement - some in regular classes, and some already in the EMR program. Of the 42 children who were initially classified as regular, 39 were subsequently placed in a special class and only three remained in the regular class. An examination of the adaptive behavior profiles for these children either as mean percentile ranks (Table 10) or as profiles (Figures 1 and 2) indicates that the children classified as regular who remain in the regular class after evaluation perform at higher levels of adaptive behavior than children in the other two categories. Although the sample size of the group who remained in regular classes was only three, it does appear that the Adaptive Behavior Scale results may have been a factor in determining which children would remain in the regular class and which children would be or remain eligible for special education placement.

The mean domain scores and profiles of children of different ethnic groups from regular classes, who, after being evaluated for EMR placement remained in the regular class are presented on Table 11 and Figure 3 and 4. The one black child who was referred demonstrated consistently higher adaptive behavior skills on Part One than the two white children. Part Two domain scores suggest different types of social emotional functioning for the three pupils, with the black child being rated as more acting out, and the white children considered to be more withdrawn. The contrast between adaptive behavior profiles for these children lead us to conclude that the Adaptive Behavior profile alone cannot explain the decision to continue the two white children in the regular class rather than to place them in a special program. The adaptive behavior profile of the black child shows clearly that he or she would not be eligible for the educable mentally retarded program and was probably a factor in the decision to continue the regular class assignment.

Table 12 and Figures 5 and 6 display the ethnic breakdown of children who were initially classified as regular, but after the evaluation were placed in special education classes. The profiles of white, black, and Spanish background children in this category were very similar; all were performing at an extremely low level on the Part One domains and all evidenced a significant level of social-emotional problems on the Part Two domains. The IQ scores available for nine children out of 39 in this category showed that the blacks had slightly higher scores than either the whites or Spanish-surnamed children, but the scores of all of these children were in the EMR range.

The adaptive behavior profile of the children who were considered to be eligible for special placement provide an indication of their self help and social skills. Regardless of ethnic status all of these children were functioning at or below the 5th percentile on personal independence and cognitive skills. They performed better on job-related tasks in school (Vocational Activity) and in situations which required them to carry out assignments (Responsibility). It is significant, however, that these pupils evidence little initiative or voluntary participation in school and they functioned at a very low level in activities requiring self direction. In other words, more than 95% of their age peers evidenced better independent functioning and self help skills as well as the motivation to participate in the life of the school. With respect to social-emotional difficulties as measured by the Part Two domains, these children are typical of 80% of the population in the absence of significant acting out behaviors, but they tend to be more withdrawn and have somewhat more problems in interpersonal behavior.

Children who are referred for evaluation for EMR programs evidently have some vision or hearing problems or evidence less mature physical development than their age peers. It is of great interest to those responsible for the

education of handicapped children in school that the Spanish-surnamed pupils had the lowest levels of physical development ratings on the Adaptive Behavior Scale on all of the comparisons of groups by ethnic status. This means that their poorer adaptive behavior performance may accompany problems of sensory deficits, immature motor development and motor coordination problems, and that effort should be made to obtain further medical evaluation of any children with raw scores less than 20 on the Physical Development domain in an effort to find and treat undiscovered medical problems.

The final group of children whose adaptive behavior profiles were abstracted for analysis were those in EMR programs who, after evaluation stayed in the EMR classes. On Table 10 and Figures 1 and 2 we showed that their performance as a group was lower than the other groups on Independent Functioning, Physical Development, Economic Activity, Language Development, and Number and Time Concepts, but higher on the personal and social responsibility domains of Self Direction, Responsibility, and Socialization. Though these differences in average percentiles between children being assigned to and those already in EMR classes were very small, they are worthy of follow-up by other investigators interested in the adaptive behavior characteristics of children who are functioning at the educable mentally retarded level.

When we separated the EMR pupils by ethnic status who remained in the EMR program after evaluation as shown on Table 13 and Figures 7 and 8, the black pupils performed better than the other two groups on Independent Functioning, Economic Activity, and Vocational Activity while the whites were better on language development, self direction, and socialization. The Spanish-surnamed pupils were lowest on all domains, and this low level of performance is again accompanied by the possibility of physical handicaps. Without more information than is available from this study, we can only speculate as to

other handicapping conditions which have affected the adaptive behavior functioning of EMR Spanish-background children in this study.

Conclusion

In this substudy we inquired into the extent of use of the Adaptive Behavior Scale by psychologists and the relationship between training in the use of the Scale and perceptions of the efficacy of its measures. A second objective was to examine the adaptive behavior profiles of children with different placement outcomes.

With respect to the use of the Scale in California schools our findings from a survey of representative school psychologists showed that 80% had obtained teacher ratings on the Scale 10 or fewer times, and 30% of this group reported never using the Scale at all. We concluded that a large majority of psychologists could not be considered proficient in the use of the Scale if one considered the number of Scales administered as a criterion of competence.

Turning our attention to parent interviews as another source of evidence of the use of the Scale, we found that 30% of psychologists had never interviewed a parent and only a rare psychologist had conducted more than 10 parent interviews using the Adaptive Behavior Scale.

We next examined the relationship of training in the use of the Scale and perceptions of the Scale's usefulness. On the basis of the training criteria which we defined, we concluded that about 30 to 45% of psychologists had been introduced to the Scale in assessment workshops, trained others, or participated in special courses, all of which would be necessary before one could be assumed to have a minimal level of assessment competence. The importance of training was shown to be crucial in the psychologist's evaluation of the adequacy of the obtained measures and the usefulness of the Scale for placement and program

decisions. In general the more extensive the training the more positive the judgment of the psychologist about the utility of the adaptive behavior assessment the Scale provides. The most negative perceptions of the Scale were given by psychologists who had not been trained, but who reported using the Scale 11 or more times to evaluate EMR referrals or children already in EMR programs. Considering the importance of training in the use of the Scale, especially in the light of the essential information needed to evaluate mental retardation, it seems crucial that the State Department of Education or local school districts institute training workshops on the use and interpretation of the Adaptive Behavior Scale.

A school district whose psychologists reported the most training provided data by which to study the evaluation outcomes of pupils who were being assessed with the Scale. The Adaptive Behavior Scale was being used in periodic evaluations of children in special education programs, to determine eligibility for EMR, EH, and TMR classes and in making educational plans for exceptional pupils. We examined in detail the adaptive behavior profiles of children in regular and EMR classes with differing outcomes. The profiles of regular class pupils who remained in regular classes after evaluation were higher than those who were assigned to EMR programs or those who were already in EMR classes. Even though we had no data on other types of information which contributed to the outcomes, we concluded that the information from the Adaptive Behavior Scale contributed to the decision. The similarities of adaptive behavior profiles among children of different ethnic groups with different placement outcomes were also reviewed. One finding worthy of continued study was the evidence that Spanish-surnamed children always had the lowest scores on the Physical Development domain indicating the possibility of sensory and motor handicaps and the probability that multiple factors influence the functioning of these children.

Taken together the findings from this substudy of the use of the Scale in public school settings has shown that psychologists are beginning to employ the Adaptive Behavior Scale in their evaluations of children, and that training in the use of the Scale is imperative for proper application of the results. The outcomes of pupil evaluation where Adaptive Behavior Scale profiles were available showed that information from adaptive behavior assessment contributed appropriately to educational decisions.

Taken together the findings from this substudy of the use of the Scale in public school settings has shown that psychologists are beginning to employ the Adaptive Behavior Scale in their evaluations of children, and that training in the use of the Scale is imperative for proper application of the results. The outcomes of pupil evaluation where Adaptive Behavior Scale profiles were available showed that information from adaptive behavior assessment contributed appropriately to educational decisions.

TABLE 1

Characteristics of Respondents to Questionnaire about Use of Public School Version of the Adaptive Behavior Scale

1A[1]
Type of School District

	F	Adj.%
Unified	81	60.9
Elementary	23	17.3
High school	13	9.8
County	11	8.3
Elementary and High School	5	3.8

1B
Location of School District

	F	Adj.%
Rural	17	13
Small city	27	20.6
Suburban city	47	35.9
Large city	22	16.8
Urban city	18	13.7

1B
Size of School District

	F	Adj.%
< 1000	45	35.2
1000 to 4999	6	4.7
5000 to 9999	16	12.5
10000 to 14999	34	26.6
15000 to 20000	25	19.5
> 20000	2	1.6

1D
Position of Respondent to Questionnaire

	F	%
Psychologist	125	93.3
Special education director	3	2.2
Special education teacher	2	1.5
Social worker	1	.7
Intern	2	1.5
Psychometrist	1	.7

[1]The school districts represented in the survey were located in 32 counties from the State of California. In all counties with the exception of Los Angeles (40 respondents) and Orange (20 respondents), the number of respondents was 7 or lower. We consider the sample of respondents to be fairly representative of the State's school districts.

TABLE 2

Distribution of Subjects for the Study of

Outcomes of Adaptive Behavior Assessment

Current Placement	Ethnic Status	Age and Sex																								Total
		7		8		9		10		11		12		13		14		15		16		17		18		19		
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Regular	White	0	0	2	2	2	2	4	0	3	3	2	1	2	2	2	1	0	0	3	0	0	1	1	0	1	0	34
	Black	1	0	5	2	6	2	5	4	4	4	6	1	4	3	6	0	2	0	2	0	1	2	4	0	1	0	65
	Spanish	0	1	2	2	3	4	3	2	1	3	3	0	6	3	1	3	0	1	0	0	1	0	0	0	0	0	39
	Other	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
EMR	White	1	0	2	1	9	3	7	12	6	7	7	5	8	6	6	6	3	1	7	4	5	7	3	3	5	5	129
	Black	0	0	2	1	3	0	7	4	24	8	20	14	16	11	13	16	5	9	6	5	11	4	8	8	4	3	202
	Spanish	0	0	1	1	3	0	4	5	9	4	10	1	9	5	8	8	4	4	7	3	3	2	6	1	3	4	105
	Other	0	0	0	0	1	0	0	0	3	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	5
TMR	White	0	0	0	1	1	1	0	0	0	0	1	1	1	0	0	1	0	0	2	0	0	0	4	2	3	3	21
	Black	0	1	0	0	0	0	1	1	1	0	0	0	1	0	2	1	0	0	0	0	0	0	0	0	0	0	8
	Spanish	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
	Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	White	0	0	0	1	2	0	2	0	2	1	2	1	2	0	0	1	1	0	1	0	1	0	0	0	0	1	18
	Black	0	0	2	0	0	0	1	1	0	0	2	0	0	0	2	0	0	0	0	1	0	0	0	1	0	0	10
	Spanish	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Total	3	2	16	11	30	12	34	30	53	30	54	24	51	30	40	38	15	15	28	13	22	16	26	15	17	16	641

TABLE 3

Number of Adaptive Behavior Scales Administered

by Interviewing Teachers

Interviewing Teachers

	F	%
None	27	20.1
1 to 10	76	60.5
11 +	26	19.4

TABLE 4

Number of Adaptive Behavior Scales Administered

by Interviewing Parents

Interviewing Parents

	F	%
None	39	29.1
1 +	95	70.9

Extent of Training in the Use of

Adaptive Behavior Scales

TABLE 5

Proportion of Respondents
Attending State Assessment Workshops

State workshop

	F	%
Yes	106	79.1
No	28	20.9

TABLE 6

Proportion of Respondents
Who Reported that They had
Trained Teachers to Use
the Adaptive Behavior Scale

Total Teachers Trained

	F	%
None	75	56.0
1 +	59	44.0

TABLE 7

Proportion of Respondents Reporting
Training Activities in Addition to
Attending State Assessment Workshop and
Training Teachers to Use the Scale

Other Training

	F	%
None	88	65.7
Workshops	19	14.2
District in-service or other courses	18	13.5
Other	9	6.7

TABLE 8

Perceived Accuracy and Usefulness of the Adaptive Behavior Scale

as a Function of Number of Scales Used and Extent of Training

Perceived accuracy and usefulness of Scale	Number of ratings given by interviewing teacher	No Training						Training							
		State workshop not attended		No teachers trained		No other training		State workshop attended		Attended other workshops		Trained teachers		Participated in district in-service courses	
		% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No	% Yes	% No
Accurate assessment as reported by parent - EMR	None	75	25	90	10	89	11	100	0	-	-	100	0	100	0
	1-10	55	45	45	55	48	52	54	46	57	43	63	37	91	9
	11 +	0	100	0	100	50	50	63	37	33	67	80	20	100	0
Accurate assessment as reported by parent - TMR	None	100	0	100	0	100	0	100	0	-	-	100	0	100	0
	1-10	100	0	78	22	78	22	79	21	75	25	86	14	100	0
	11 +	0	100	67	33	86	14	71	29	67	33	67	33	100	0
Accurate assessment as reported by teacher - EMR	None	50	50	83	17	75	25	100	0	-	-	-	-	100	0
	1-10	80	20	66	34	66	34	69	31	75	25	75	25	82	18
	11 +	25	75	22	78	62	38	67	33	33	67	81	19	100	0
Accurate assessment as reported by teacher - TMR	None	100	0	100	0	100	0	100	0	-	-	100	0	100	0
	1-10	100	0	87	13	90	10	90	10	86	14	95	5	100	0
	11 +	50	50	80	20	89	11	73	27	67	33	67	33	100	0
Useful for referral EMR	None	67	33	67	33	70	30	75	25	-	-	100	0	100	0
	1-10	50	50	37	63	40	60	46	54	54	46	56	44	64	36
	11 +	0	100	11	89	53	47	63	37	33	67	79	21	100	0
Useful for referral TMR	None	100	0	78	22	75	25	75	25	-	-	100	0	100	0
	1-10	88	12	63	37	67	33	65	35	80	20	73	27	73	27
	11 +	0	100	25	75	78	22	71	29	33	67	79	21	100	0
Useful for program decisions	None	75	25	62	38	69	31	64	36	-	-	100	0	50	50
	1-10	40	60	45	55	49	51	52	48	43	57	57	43	80	20
	11 +	25	75	33	67	63	37	67	33	33	67	75	25	50	50

TABLE 9

Purpose of Evaluation by Outcome by Ethnic Status in Three California School Districts

Purpose of Evaluation		Outcome of Evaluation: Remain in Current Placement			Change from Special Education to Regular			Change from Regular to Special Education			Eligible for Special Education, but on Waiting List			Not Determined			Total
		White	Black	Spanish	White	Black	Spanish	White	Black	Spanish	White	Black	Spanish	White	Black	Spanish	
Annual or Periodic Evaluation	%	88	90	93	3	9	7	2	1	0	2	0	0	5	0	0	
	N	(106)	(114)	(78)	(4)	(11)	(6)	(2)	(1)	(0)	(2)	(0)	(0)	(6)	(0)	(0)	330
Determine Eligibility for EMR	%	59	20	17	-	-	-	41	73	83	0	2	0	0	5	0	
	N	(16)	(8)	(6)	-	-	-	(11)	(30)	(30)	(0)	(1)	(0)	(0)	(2)	(0)	104
Determine Eligibility for EH	%	46	53	15	-	-	-	27	33	70	27	7	15	0	7	0	
	N	(7)	(8)	(2)	-	-	-	(4)	(5)	(9)	(4)	(1)	(2)	(0)	(1)	(0)	43
Determine Eligibility for TMR	%	67	50	0	-	-	-	0	50	0	33	0	0	0	0	0	
	N	(2)	(1)	(0)	-	-	-	(0)	(1)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	5
Determine Eligibility for Reassignment to Regular Class	%	84	84	100	16	15	0	-	-	-	0	1	0	0	0	0	
	N	(38)	(82)	(16)	(7)	(15)	(0)	-	-	-	(0)	(1)	(0)	(0)	(0)	(0)	159
Vocational Eligibility	%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	N	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	0
Other Non-educational evaluation	%	0	0	0	0	100	0	100	0	0	0	0	0	0	0	0	
	N	(0)	(0)	(0)	(0)	(1)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	2
Total	N	169	213	102	11	27	6	18	37	39	7	3	2	6	3	0	643

34 a

34 B

Table 10

Outcome of Evaluation and Adaptive Behavior Scale Profile

Ages 8-12

Purpose of Evaluation: Determine Eligibility for EMR Placement

Outcome of Evaluation	IQ	N for AAMD AB Profile	Adaptive Behavior Scale - Mean Percentiles: Part One								
			Independent Functioning	Physical Development	Economic Activity	Language Development	Numbers & Time	Vocational Activity	Self-Direction	Responsibility	Socialization
Regular Classification Remain in Regular Class	67.5 (N=2)	3	23.7	76.3	13.7	11.3	9.7	42.0	25.3	79.3	43.7
Regular Classification Change to Special Ed.	68.1 (N=9)	39	3.8	22.2	3.4	2.0	1.5	22.9	6.2	20.7	11.0
EMR Classification Remain in EMR	65.8 (N=5)	9	1.2	17.3	2.2	2.2	.8	22.8	12.7	23.0	11.2

Outcome of Evaluation	IQ	N for AAMD AB Profile	Part Two											
			Violent & Destructive Behavior	Antisocial Behavior	Rebellious Behavior	Untrustworthy Behavior	Withdrawal	Stereotyped Behavior & Odd Mannerisms	Inappropriate Interpersonal Manners	Unacceptable Vocal Habits	Unacceptable or Eccentric Habits	Hyperactive Tendencies	Psychological Distrubances	Use of Medications
Regular Classification Remain in Regular Class	67.5 (N=2)	3	76.0	73.3	78.7	85.7	81.3	89.7	94.7	89.3	75.0	93.3	80.7	97.3
Regular Classification Change to Special Ed.	68.1 (N=9)	39	84.4	74.4	85.4	81.2	90.0	90.9	95.2	88.6	75.6	88.9	80.5	98.0
EMR Classification Remain in EMR	65.8 (N=5)	9	78.2	62.6	80.6	76.8	92.3	91.6	94.3	87.4	80.8	86.3	77.0	98.1

Determine Eligibility for EMR Placement

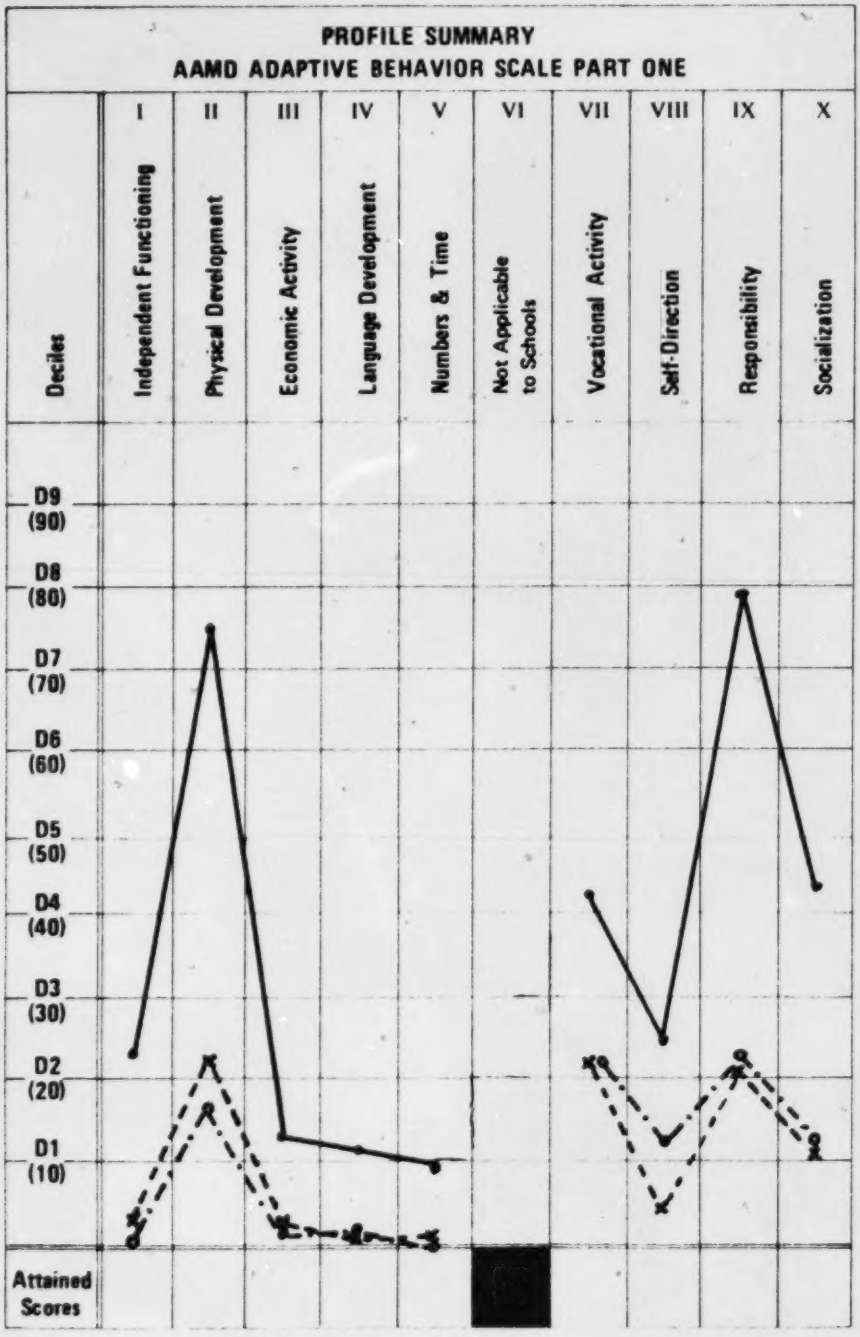
Identification Outcome of Evaluation

Figure 1

Age 8 - 12

Sex Both Ethnic Status: All

Date of Administration Spring 1977



Reg Class - Remain in Regular Class

Reg Class - Change to Special Class

EMR Class - Remain in EMR

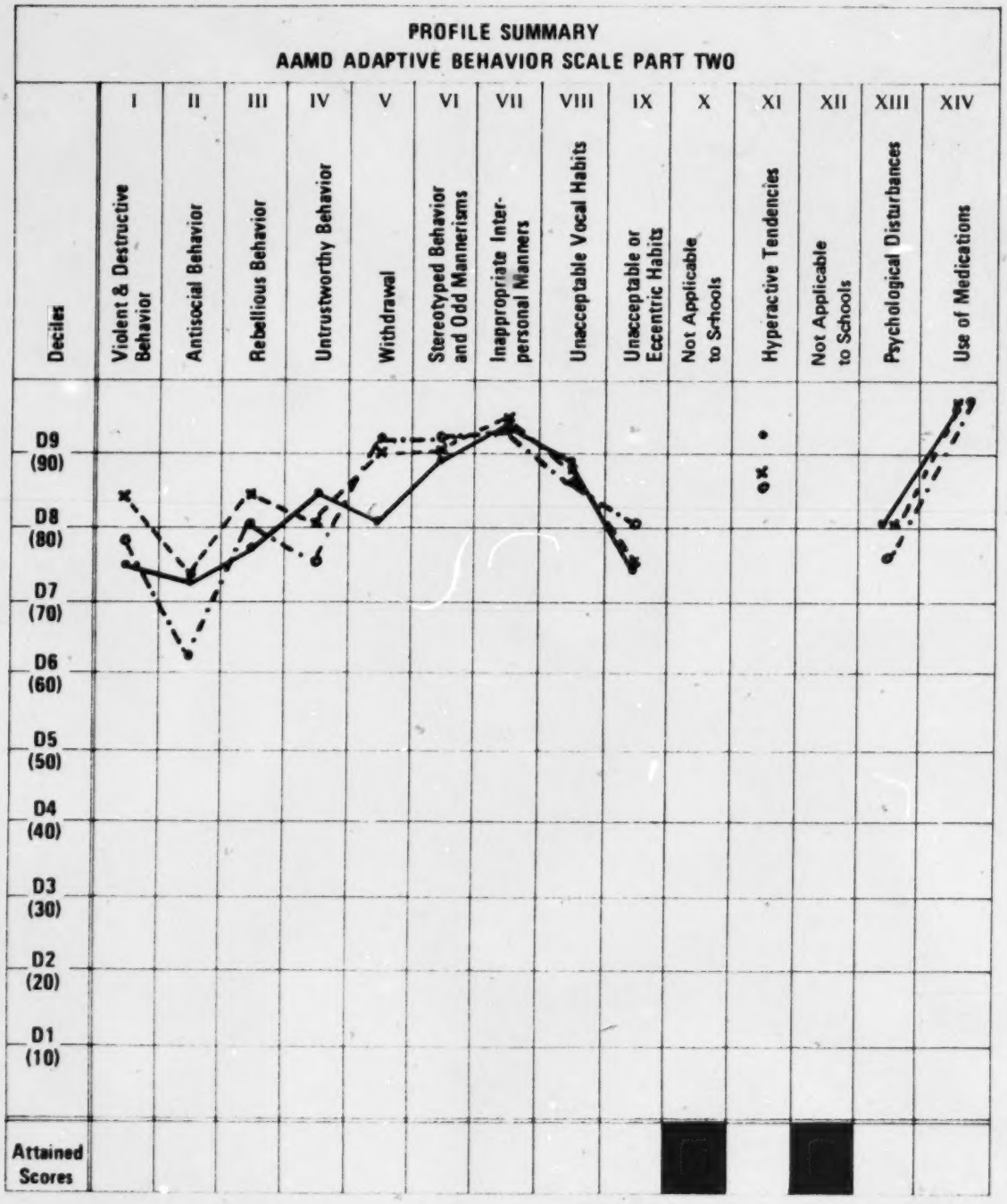
Determine Eligibility
for EMR Placement

Identification Outcome of Evaluation

Age 8 - 12

Sex Both Ethnic Status: All

Date of Administration Spring 1977



Reg Class - Remain in Regular Class

Reg Class - Change to Special Class

EMR Class - Remain in EMR

Table 11

Mean Adaptive Behavior Domain Scores for Regular Classification Pupils Who Remain in Special Class: Ethnic Status by AAMDAB Scale Profile

Ages 8-12

Purpose of Evaluation: Determine Eligibility for EMR Placement

Regular Classification, Remain in Regular Class	IQ	N for AAMD AB Profile	AAMD Adaptive Behavior Scale - Mean Percentiles: Part One								
			Independent Functioning	Physical Development	Economic Activity	Language Development	Numbers & Time	Vocational Activity	Self-Direction	Responsibility	Socialization
White	69 (N=1)	2	5.0	65.0	2.0	2.0	2.5	25.5	6.5	69.5	24.5
Black	66 (N=1)	1	61.0	99.0	37.0	30.0	24.0	75.0	63.0	99.0	82.0

Regular Classification, Remain in Regular Class	IQ	N for AAMD AB Profile	Part Two											
			Violent & Destructive Behavior	Antisocial Behavior	Rebellious Behavior	Untrustworthy Behavior	Withdrawal	Stereotyped Behavior & Odd Mannerisms	Inappropriate Interpersonal Manners	Unacceptable Vocal Habits	Unacceptable or Eccentric Habits	Hyperactive Tendencies	Psychological Disturbances	Use of Medications
White	69 (N=1)	2	72.5	66.5	73.0	89.5	94.0	93.5	95.0	91.0	84.0	90.5	76.5	97.5
Black	66 (N=1)	1	83.0	87.0	90.0	78.0	56.0	82.0	94.0	86.0	57.0	99.0	89.0	97.0

Figure 3

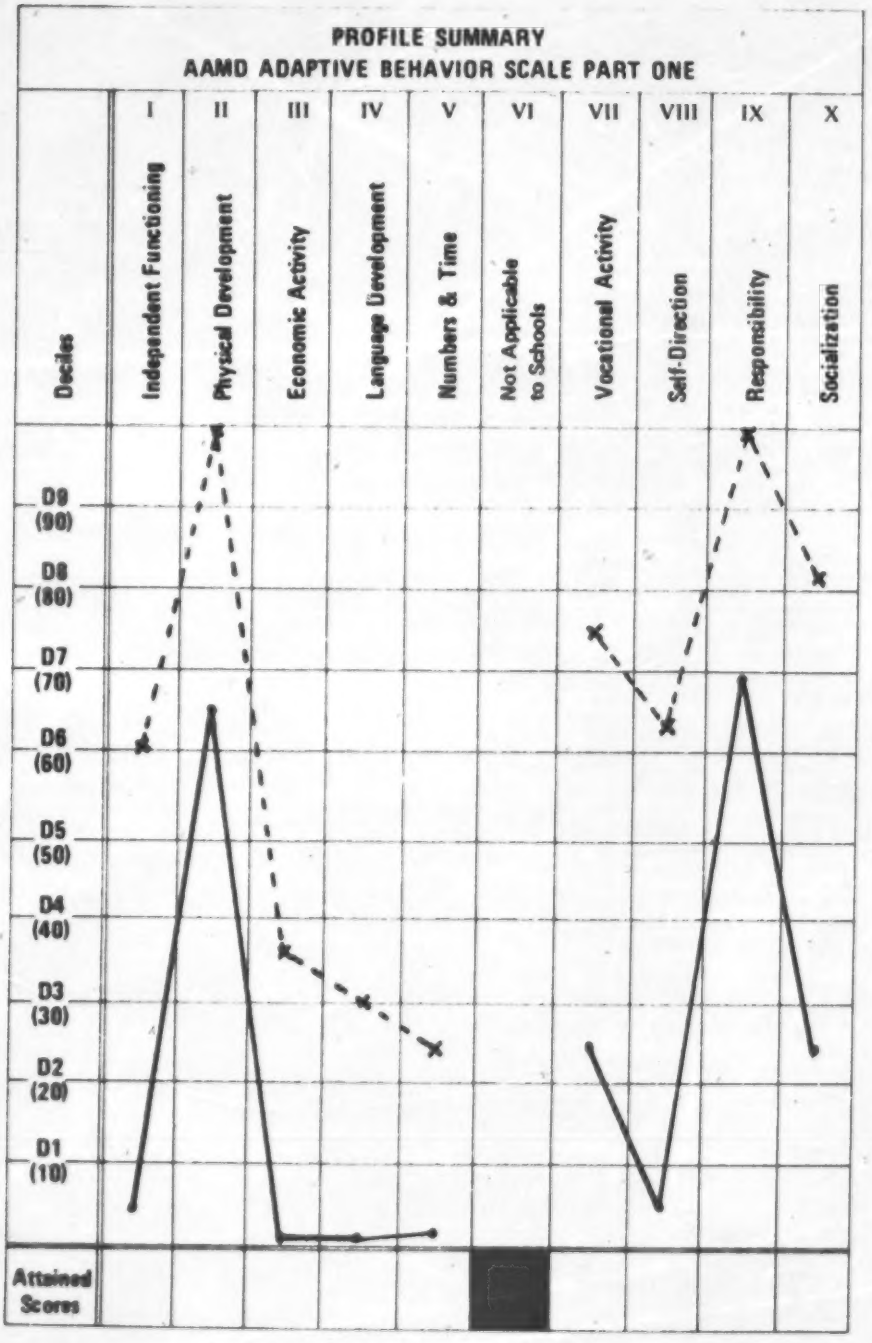
Determine Eligibility for EMR Placement

Identification Regular Classification, Remain in Regular Class

Age 8 - 12

Sex Both Ethnic Status: White, Black

Date of Administration Spring 1977



White

Black

Determine Eligibility for EMR Placement

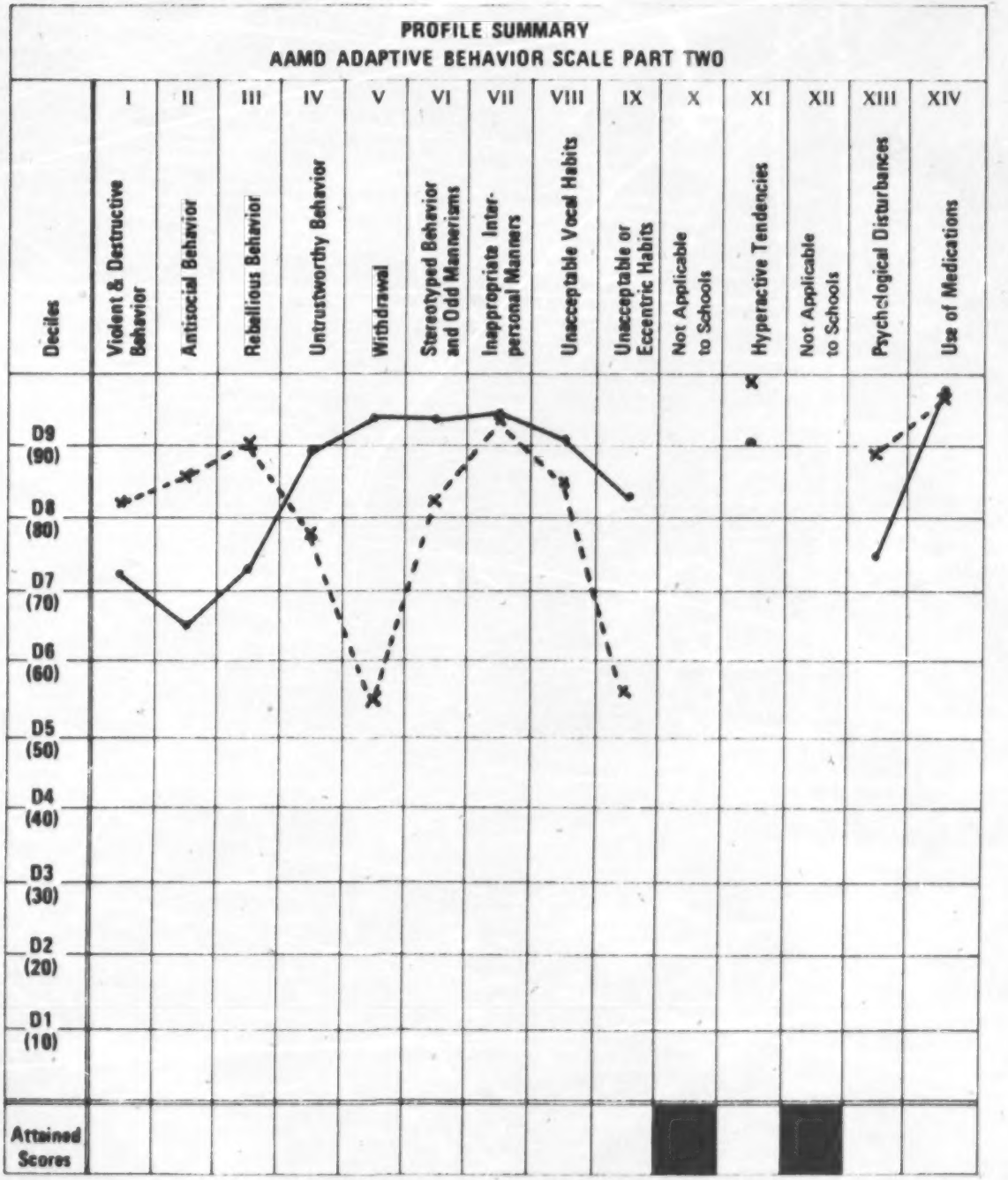
Figure 4

Identification: Regular Classification — Remain in Regular Class

Age: 8 - 12

Sex: Both

Date of Administration: Spring 1977



White ——●——

Black ✱- - - - - ✱

Table 12

Mean Adaptive Behavior Domain Scores for Regular Classification Pupils Who Change to Special Class: Ethnic Status by AAMDAB Scale Profile

Ages 8-12

Purpose of Evaluation: Determine Eligibility for EMR Placement

Regular Classification, Change to Special Ed.	IQ	N for AAMD AB Profile	Adaptive Behavior Scale - Mean Percentiles: Part One								
			Independent Functioning	Physical Development	Economic Activity	Language Development	Numbers & Time	Vocational Activity	Self-Direction	Responsibility	Socialization
White	66.5 (N=2)	6	3.5	28.2	4.3	1.3	.2	17.0	5.8	17.3	6.2
Black	71.3 (N=4)	17	4.7	33.1	5.3	3.9	2.7	27.2	5.5	21.1	13.6
Spanish	65.0 (N=3)	16	2.9	15.3	.9	.4	.8	20.4	7.0	21.7	10.0

Regular Classification, Change to Special Ed.	IQ	N for AAMD AB Profile	Part Two											
			Violent & Destructive Behavior	Antisocial Behavior	Rebellious Behavior	Untrustworthy Behavior	Withdrawal	Stereotyped Behavior & Odd Mannerisms	Inappropriate Interpersonal Manners	Unacceptable Vocal Habits	Unacceptable or Eccentric Habits	Hyperactive Tendencies	Psychological Distrubances	Use of Medications
White	66.5 (N=2)	6	82.0	69.7	87.3	79.5	96.0	92.5	95.7	92.5	75.0	87.8	88.0	98.0
Black	71.3 (N=4)	17	84.7	76.7	83.9	84.2	89.5	90.7	94.4	86.4	76.1	87.7	76.5	97.9
Spanish	65.0 (N=3)	16	85.0	73.9	86.4	78.6	87.6	90.5	95.8	89.4	75.3	90.6	81.9	98.1

Determine Eligibility for EMR Placement

Figure 5

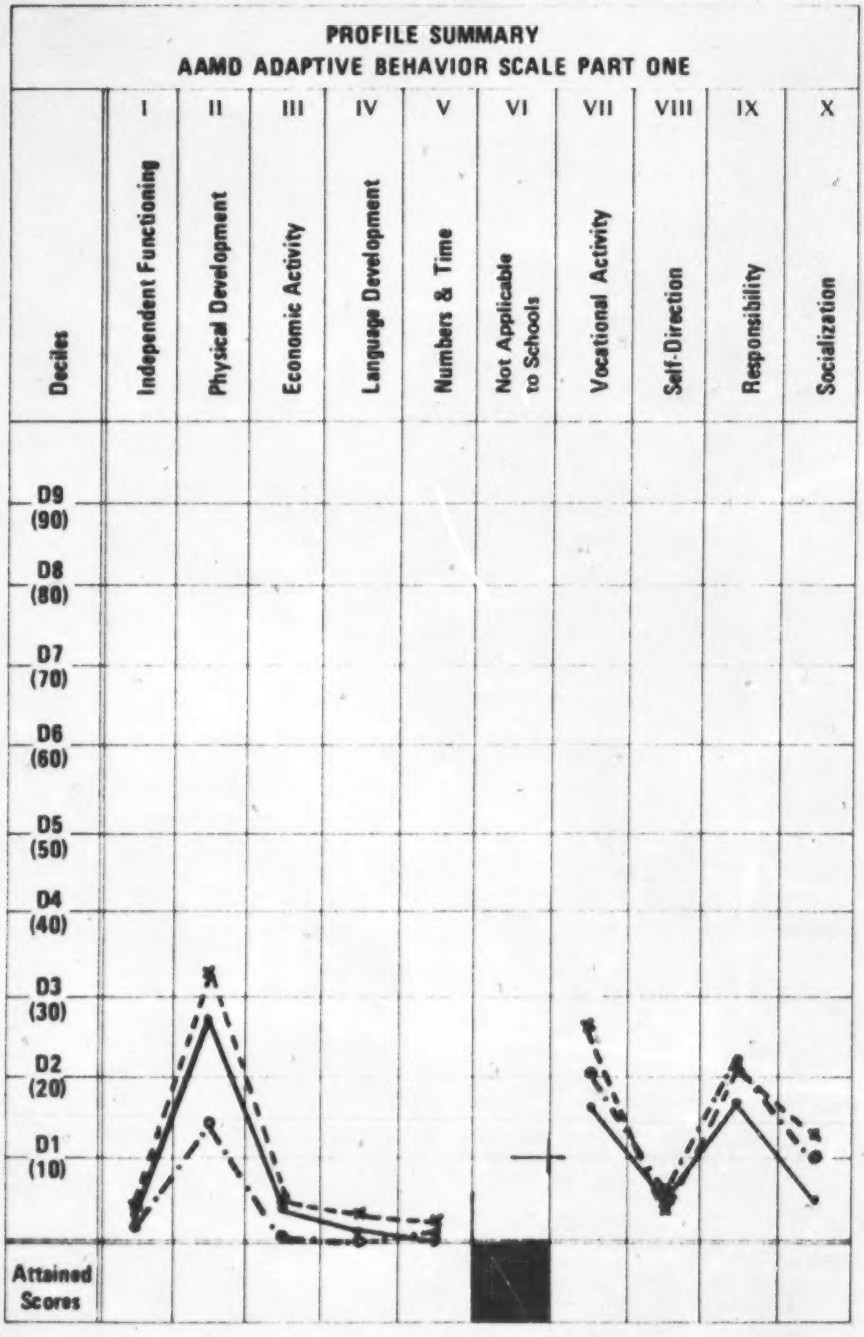
Identification: Regular Classification, Change to Special Education

Age: 8 - 12

Sex: Both

Ethnic Status: White, Black, Spanish

Date of Administration: Spring 1977



Determine Eligibility for EMR Placement

Figure 6

Identification: Regular Classification, Change to Special Education

Age: 8 - 12

Sex: Both

Ethnic Status: White, Black, Spanish

Date of Administration: Spring 1977

PROFILE SUMMARY
AAMD ADAPTIVE BEHAVIOR SCALE PART TWO

Deciles	I Violent & Destructive Behavior	II Antisocial Behavior	III Rebellious Behavior	IV Untrustworthy Behavior	V Withdrawal	VI Stereotyped Behavior and Odd Mannerisms	VII Inappropriate Interpersonal Manners	VIII Unacceptable Vocal Habits	IX Unacceptable or Eccentric Habits	X Not Applicable to Schools	XI Hyperactive Tendencies	XII Not Applicable to Schools	XIII Psychological Disturbances	XIV Use of Medications
D9 (90)														
D8 (80)														
D7 (70)														
D6 (60)														
D5 (50)														
D4 (40)														
D3 (30)														
D2 (20)														
D1 (10)														
Attained Scores														

White ——●——

Black ×– – – – – ×

Spanish ○–·–·–·–○

Table 13

Mean Adaptive Behavior Domain Scores for EMR Classification Pupils Who Remain in EMR: Ethnic Status by AAMDAB Scale Profile

Ages 8-12

Purpose of Evaluation: Determine Eligibility for EMR Placement

EMR Classification, Remain in EMR	IQ	N for AAMD AB Profile	Adaptive Behavior Scale - Mean Percentiles: Part One: Independent Functioning	Physical Development	Economic Activity	Language Development	Numbers & Time	Vocational Activity	Self-Direction	Responsibility	Socialization
White	63 (N=1)	2	0.0	52.5	0.0	9.5	2.0	25.5	39.0	37.5	28.0
Black	64.5 (N=2)	2	4.0	14.0	8.0	.5	0.0	34.5	9.5	29.0	10.0
Spanish	68.5 (N=2)	5	.6	4.6	.8	0.0	.6	17.0	3.4	17.2	5.0

EMR Classification, Remain in EMR	IQ	N for AAMD AB Profile	Part Two: Violent & Destructive Behavior	Antisocial Behavior	Rebellious Behavior	Untrustworthy Behavior	Withdrawal	Stereotyped Behavior & Odd Mannerisms	Inappropriate Interpersonal Manners	Unacceptable Vocal Habits	Unacceptable or Eccentric Habits	Hyperactive Tendencies	Psychological Disturbances	Use of Medications
White	63 (N=1)	2	66.0	53.5	78.0	73.0	78.0	89.5	96.0	91.0	73.0	83.0	63.0	98.0
Black	64.5 (N=2)	2	79.5	50.0	74.0	76.5	95.5	89.5	92.0	82.5	64.5	85.5	80.5	98.0
Spanish	68.5 (N=2)	5	82.6	71.2	84.2	78.4	97.0	93.2	94.6	88.0	84.0	88.0	81.2	98.2

Determine Eligibility
for EMR Placement

EMR Classification,
Identification Remain in EMR

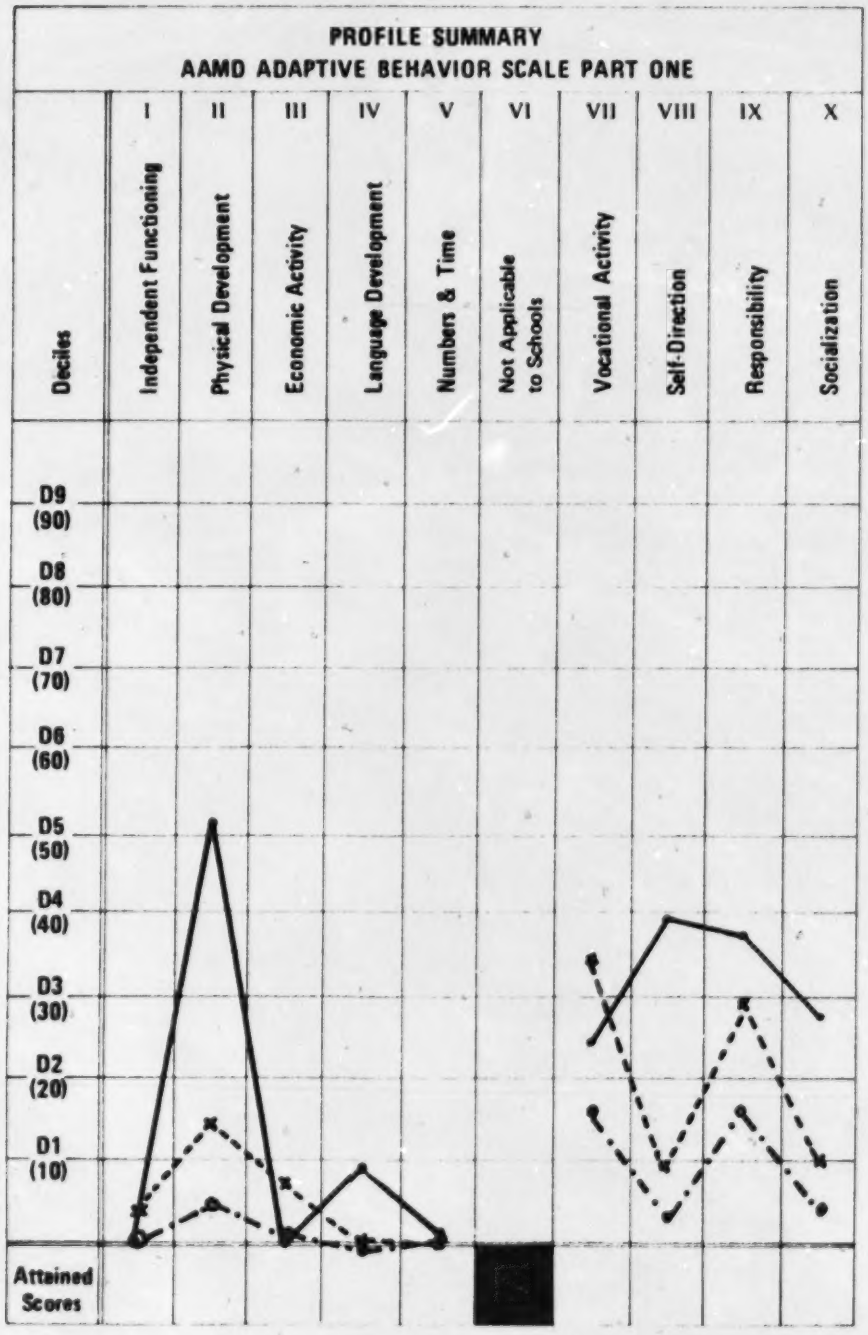
Figure 7

Age 8 - 12

Sex Both

Ethnic Status:
White, Black, Spanish

Date of Administration Spring 1977



White ——————

Black ✕– – – – ✕

Spanish ●– · – · – · –●

Determine Eligibility for EMR Placement

Figure 8

Identification: EMR Classification, Remain in EMR

Age: 8 - 12

Sex: Both

Ethnic Status: White, Black, Spanish

Date of Administration: Spring 1977